Appendix H -- Preventing and Managing Illness

* Examples of How Some Childhood Infectious Diseases are Spread
* Medication Record
* Instructions for Medication
* Employment Health Clearance Form
* Child Care Staff Health Assessment
* List of Reportable Communicable Diseases
* When a Caregiver is Too Sick to Work
* Immunization Letter for Parents
* Consent for Exchange of Information

Examples of How Some Childhood Infectious Diseases are Spread

How the Disease is Spread	Behaviors that Spread	Examples of Diseases	Possible Symptoms
Through Air or Respiratory Transmission:			
• Breathing germs in the air and contact with infected saliva	• Coughing or sneezing into the air • Kissing on the mouth • Sharing mouthed toys • Wiping noses without thorough handwashing • Poor ventilation	• Cold • Flu • Measles • Pink eye • Chicken pox • Tuberculosis (TB)	• Coughing • Fever • Rash • Runny nose • Sore throat • Earache
Through Stool or Fecal-Oral Transmission:			
• Mouth contact with items and hands contaminated by infected stool	• Diapering and toileting or food preparation without thorough handwashing • Sharing mouthed toys • Unsafe food preparation • Not disinfecting • Diapering areas	• Salmonella • Shigella • Giardia • Pinworms • Hand, foot, and mouth disease • Hepatitis A • Polio • E. coli	• Stomach upsets • Nausea • Vomiting • Diarrhea
Through Direct Contact:			
• Contact with infected hair, skin, and objects	• Touching skin or hair that is infected • Sharing clothing, hats and brushes that are infected	• Herpes • Ringworm • Scabies • Head lice • Impetigo • Chickenpox (Varicella)	• Rash • Oozing sores • Itching • Visible nits or eggs
Through Blood Transmission:			
• Contact with infected blood and sometimes other body fluids	• Sexual contact • Changing bloody diapers without gloves • Providing first aid without gloves • Getting infected blood or body fluids into broken skin, eyes, or mouth	• HIV/AIDS • Hepatitis B • Cytomegalo-virus (CMV)	• Fatigue • Weight loss • Yellow skin

Medication Record

Must be filled out by the person who gives the medication.

Child's Name: _____

Date of Birth: _____

Medication:

date	time	initials	date	time	initials

Signatures that correspond to initials of persons giving medication:

Instructions for Medication

Child's name: _____

Reason for medication: _____

Name of medication: _____

How much to give: _____

When to give: _____

How to give: ❑ oral (by mouth) ❑ topical (to skin) ❑ other

When should the treatment be stopped? _____

Requires refrigeration: ❑ yes ❑ no

Possible side effects:

_____

Special instructions/suggestions (e.g. take with food, follow with favorite drink):

Parent signature: _____ Date: _____

Physician signature*: _____ Date: _____

Physician's Phone: (_____) _____

***NOTE:**
You need a physician's signature for **non-prescription** medications if:

1. There are no instructions on the container for use of the medication for child's age, or
2. The medication is **not** listed below.
   - Antihistamines
   - Non-aspirin pain relievers and fever reducers
   - Cough medicines
   - Decongestants
   - Anti-itching creams
   - Diaper ointments and powders
   - Sun screens
   - Vitamins, including iron pills

Employment Health Clearance Form

Health Care Provider: Please return this page only to the _____ care agency.

Date: _____

Patient Name (Or ID Number)_____

1. Does this person have any condition/illness that would prevent him or her from working in a child care setting giving direct services to children ages _____ to _____ ? ❑yes ❑no

   If yes, please explain: _____

2. Does this person have any other limiting condition(s) that would prevent him or her from working in a child care setting giving direct services to children as described in No.1? ❑yes ❑no
   If yes, please explain: _____

Based upon my evaluation: (select one)

❑ Applicant can perform the job, including essential and marginal functions, without direct threat to the health or safety of self or others.

❑ Applicant can perform the essential functions of the job without direct threat to the health and safety of self or others.

❑ Applicant can perform the essential functions of the job without direct threat to the health and safety of others if the following restrictions can be accommodated:

Child Care Staff Health Assessment

Employer should complete this section.

Name of person to be examined: _____

Employer for whom examination is being done: _____

Employer's Location: _____ Phone number: (_____) _____

Purpose of examination: ❑ pre-employment (with conditional offer of employment)

❑ annual re-examination

Type of activity on the job: ❑ lifting/carrying children ❑ close contact with children ❑ food preparation

❑ desk work ❑ driver of vehicles ❑ food preparation facility maintenance

Part I and Part II below must be completed and signed by a licensed physician or CRNP.

Based on a review of the medical record, health history. and examination, does this person have any of the following conditions or problems that might affect job performance or require accommodation?

Date of exam: _____

Part I: Health Problems

	(circle)	
• visual acuity less than 20/40 (combined, obtained with lenses if needed)?	yes	no
• decreased hearing (less than 20 db at 500, 1000, 2000, 4000 Hz)?	yes	no
• respiratory problems (asthma, emphysema, airway allergies, current smoker, other)?	yes	no
• heart, blood pressure, or other cardiovascular problems?	yes	no
• gastrointestinal problems (ulcer, colitis, special dietary requirement, obesity, other)?	yes	no
• endocrine problems (diabetes, thyroid, other)?	yes	no
• emotional disorders or addiction (depression, drug or alcohol dependency, other)?	yes	no
• neurologic problems (epilepsy, Parkinsonism, other)?	yes	no
• musculoskeletal problems (low back pain, neck problems, arthritis, limitations on activity)?	yes	no
• skin problems (eczema, rashes, conditions incompatible with frequent hand washing, other)?	yes	no
• immune system problems (from medication, illness, allergies, and sensitivities to materials)?	yes	no
• need for more frequent health visits or sick days than the average person?	yes	no
• other special medical problem or chronic disease that requires work restrictions or accommodation?	yes	no

Part II: Infectious Disease Status

Immunizations now due/overdue for:

• dT (every 10 years)	yes	no
• MMR (2 doses for persons born after 1989; 1 dose for those born in or after 1957)	yes	no

Child Care Staff Health Assessment Page Two

Part II: Infectious Disease Status (continued) (circle)

- Polio (OPV or lPV in childhood) yes no
- Hepatitis B (3 dose series) yes no
- Varicella (2 doses or had the disease) yes no
- Influenza yes no
- Pneumococcal vaccine yes no
- Female of childbearing age susceptible to CMV or parvovirus? yes no
- Evaluation of tuberculosis status shows a risk for communicable TB? yes no
- Mantoux test date_____ Result _____

Tuberculosis status must be determined by performing the Mantoux test (intradermal, intermediate strength PPD injection with needle and syringe) for persons not previously tested positive for tuberculosis infection. For individuals over 55 years of age, and anyone with pulmonary symptoms, the Mantoux test should be performed twice if the first test is negative. The second test should be performed 1–3 weeks after the first test. Anyone with a previously positive Mantoux test, who has symptoms suggestive of active TB 500J, should have a chest x-ray. All newly positive Mantoux tests should be followed by x-ray evaluation.

Please attach additional sheet to explain all "Yes" answers above, including the follow-up plan.

Date: _____

Signature: _____

Printed last name and title: _____

Phone number of physician or CRNP: (_____) _____

I have read and understand the above information.

Date: _____

Patient's Signature: _____

Adapted from "Model Child Care Health Polices", Healthy Child Care Pennsylvania

List of Reportable Communicable Diseases

REPORTABLE DISEASES AND CHILD CARE SITES (WAC 246-100)

The following is a list of illnesses that could be a concern in child care sites. The diseases are categorized to indicate whether they are reportable. All physicians and child care facilities are required to report. This list does not represent the entire reportable disease list, but a simplified child care version. Many illnesses may be reported by mail to your local health department.

Vaccine Preventable Illness

IMMEDIATE REPORT REQUIRED when case is suspected. Prompt investigation is necessary for interruption of disease transmission and/or compilation of statistics for evaluating vaccine strategies. Telephone report preferred.

- Diphtheria
- Haemophilus influenzae type b disease
- Rubella
- Tetanus
- Pertussis
- Poliomyelitis invasive
- Measles (Rubeola)
- Mumps

Uncommon Illness with Significant Morbidity

REPORT REQUIRED. Prompt investigation is required to interrupt disease transmission. Telephone report preferred.

- Acquired Immune Deficiency Syndrome (AIDS)
- Campylobacter Enteritis
- Foodborne infections and intoxications
- Gonorrhea
- Hepatitis, viral type B
- Rheumatic Fever
- Shigellosis
- Viral Encephalitis
- Amoebiasis
- E. coli O157 H:7
- Giardiasis
- Hepatitis, viral type A
- Meningococcal disease
- Salmonellosis
- Tuberculosis
- Yersiniosis

When a Caregiver is Too Sick to Work

Most adults with mild illnesses can safely care for children. However, a caregiver may be too sick to work if she has any of the following symptoms or diagnoses:

- The caregiver does not feel well enough to comfortably fulfill her responsibilities in the program.
- The caregiver has any of the following symptoms, until a health care provider determines that the caregiver is well enough to work and that the illness is not contagious:
  - **Fever** (above 101° F, recorded orally) accompanied by behavioral changes and other signs or symptoms of illness
  - **Signs or symptoms of possibly severe illness** (e.g., extreme irritability, uncontrolled coughing, difficulty breathing, wheezing, lethargy)
  - **Diarrhea** (changes from the usual stool pattern, increased frequency of stools, looser or watery stools)
  - **Vomiting** more than once in the previous 24 hours
  - **Mouth sores** that cannot be covered
  - **Rash** with a fever or behavioral changes

- The caregiver has received any of the following diagnoses from a health care provider until treated and/or no longer contagious:
  - **Infectious conjunctivitis (pinkeye)** (with eye discharge)—until 24 hours after treatment started
  - **Scabies, head lice, or other infestation**—until 24 hours after treatment and free of nits
  - **Impetigo**—until 24 hours after treatment started
  - **Strep throat, scarlet fever, or other strep infection**—until 24 hours after treatment started and free of fever
  - **Pertussis**—until five days after treatment started
  - **Tuberculosis (TB)**—until a health care provider determines that the disease is not contagious
  - **Chicken pox**—until six days after start of the rash or until all sores have crusted over
  - **Mumps**—until nine days after start of symptoms (swelling of cheeks)
  - **Hepatitis A**—until seven days after start of symptoms (e.g., jaundice)
  - **Measles**—until six days after start of rash
  - **Rubella (German measles)**—until six days after start of rash
  - **Oral herpes** (if lesions cannot be covered)—until lesions heal
  - **Shingles** (if lesions cannot be covered)—until lesions are dry

Adapted from *Caring for Our Children*, American Academy of Pediatrics and American Public Health Association, 1992, and *Keeping Kids Healthy*, California Department of Education

Immunization Letter for Parents

Name of Agency

Dear Parent or Guardian:

I reviewed your child care center's immunization records today and found the record for _____ is incomplete.

Please update your child's immunization record with your child care center as soon as possible.

- Documentation of immunizations is missing.
- Signature needed on CIS
- Immunization form is missing

Thank you for your cooperation.

_____

Signature
Agency

Consent for Exchange of Information

Child Care: _____

Address: _____

Child's Name: _____

Birthdate: _____

Concern: _____

_____

_____

_____

Please sign and take this form with you when you go to the appointment and return the report to us as soon as possible.

Permission granted to share this information with Child Care.

Parent/Guardian: _____ Date: _____

Recommendations from Professional Examination/Evaluation:

Date of appointment: _____

Address: _____

Care Provider: _____

Phone: (_____) _____

Return this report to the Child Care Center/Home.

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Through Stool or Fecal-Oral Transmission:			
• Mouth contact with items and hands contaminated by infected stool	• Diapering and toileting or food preparation without thorough handwashing • Sharing mouthed toys • Unsafe food preparation • Not disinfecting • Diapering areas	• Salmonella • Shigella • Giardia • Pinworms • Hand, foot, and mouth disease • Hepatitis A • Polio • E. coli	• Stomach upsets • Nausea • Vomiting • Diarrhea
Through Direct Contact:			
• Contact with infected hair, skin, and objects	• Touching skin or hair that is infected • Sharing clothing, hats and brushes that are infected	• Herpes • Ringworm • Scabies • Head lice • Impetigo • Chickenpox (Varicella)	• Rash • Oozing sores • Itching • Visible nits or eggs
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• Contact with infected blood and sometimes other body fluids	• Sexual contact • Changing bloody diapers without gloves • Providing first aid without gloves • Getting infected blood or body fluids into broken skin, eyes, or mouth	• HIV/AIDS • Hepatitis B • Cytomegalo-virus (CMV)	• Fatigue • Weight loss • Yellow skin

Medication Record

Must be filled out by the person who gives the medication.

Child's Name: _____

Date of Birth: _____

Medication:

date	time	initials	date	time	initials

Signatures that correspond to initials of persons giving medication:

Instructions for Medication

Child's name: _____

Reason for medication: _____

Name of medication: _____

How much to give: _____

When to give: _____

How to give: ❑ oral (by mouth) ❑ topical (to skin) ❑ other

When should the treatment be stopped? _____

Requires refrigeration: ❑ yes ❑ no

Possible side effects:

_____

Special instructions/suggestions (e.g. take with food, follow with favorite drink):

Parent signature: _____ Date: _____

Physician signature*: _____ Date: _____

Physician's Phone: (_____) _____

***NOTE:**
You need a physician's signature for **non-prescription** medications if:

1. There are no instructions on the container for use of the medication for child's age, or
2. The medication is **not** listed below.
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Employment Health Clearance Form

Health Care Provider: Please return this page only to the _____ care agency.

Date: _____

Patient Name (Or ID Number)_____

1. Does this person have any condition/illness that would prevent him or her from working in a child care setting giving direct services to children ages _____ to _____ ? ❑yes ❑no

   If yes, please explain: _____

2. Does this person have any other limiting condition(s) that would prevent him or her from working in a child care setting giving direct services to children as described in No.1? ❑yes ❑no
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Based upon my evaluation: (select one)

❑ Applicant can perform the job, including essential and marginal functions, without direct threat to the health or safety of self or others.

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Employer for whom examination is being done: _____

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Purpose of examination: ❑ pre-employment (with conditional offer of employment)

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❑ desk work ❑ driver of vehicles ❑ food preparation facility maintenance

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Date of exam: _____

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	(circle)	
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Child Care Staff Health Assessment Page Two

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Please attach additional sheet to explain all "Yes" answers above, including the follow-up plan.

Date: _____

Signature: _____

Printed last name and title: _____

Phone number of physician or CRNP: (_____) _____

I have read and understand the above information.

Date: _____

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Adapted from "Model Child Care Health Polices", Healthy Child Care Pennsylvania

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Adapted from *Caring for Our Children*, American Academy of Pediatrics and American Public Health Association, 1992, and *Keeping Kids Healthy*, California Department of Education

Immunization Letter for Parents

Name of Agency

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- Signature needed on CIS
- Immunization form is missing

Thank you for your cooperation.

_____

Signature
Agency

Consent for Exchange of Information

Child Care: _____

Address: _____

Child's Name: _____

Birthdate: _____

Concern: _____

_____

_____

_____

Please sign and take this form with you when you go to the appointment and return the report to us as soon as possible.

Permission granted to share this information with Child Care.

Parent/Guardian: _____ Date: _____

Recommendations from Professional Examination/Evaluation:

Date of appointment: _____

Address: _____

Care Provider: _____

Phone: (_____) _____

Return this report to the Child Care Center/Home.